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SIU SPOTLIGHT

MARSHALL DENNEHEY

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WELCOME

Welcome to the first issue of Marshall Dennehey's **SIU Spotlight**, your biannual compass to navigate the ever-evolving landscape of insurance fraud from the Special Investigation Units' (SIU) perspective. In an industry where adaptability is key, staying ahead of the curve is not just an advantage, it's a necessity. Our hope is that this newsletter will be a trusted guide, delivering a comprehensive synthesis of recent trends, pivotal case law, and the latest regulatory developments shaping the insurance fraud and SIU space.

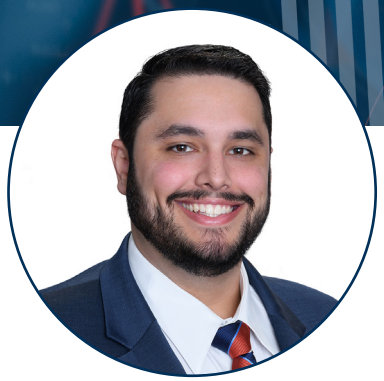
In each edition we shall curate a meticulous examination of the current state of affairs within the insurance industry, offering insights that empower professionals to make informed decisions. From emerging fraud schemes to landmark legal decisions, we bring you a 360-degree view of the challenges and opportunities that define this dynamic field.

As your dedicated source for timely and relevant information, SIU Spotlight aims to foster a community where knowledge is not only shared but also utilized to fortify the defenses against fraudulent activities. Our commitment to excellence is reflected in the in-depth analysis, expert opinions, and actionable takeaways that adorn the pages of every issue.

In our first issue, we dive into new cases from Michigan, Minnesota, and New Jersey and their impact on the industry from Matthew Burdalski, Jonathan Magpantay, and Garry Lesser. Alexander Mendez provides a look at a CPT code in Florida with a torturous history for insurance carriers. Matthew Gray discusses the history of New York State No-Fault and the problems that remain today. Ari Brownstein takes a look at an overlooked part of medical billing—anesthesia for epidural and facet injections—and how SIU should approach these bills. Finally, we focus on some of the new faces of our SIU/PIP team from New York, New Jersey and Florida.

Join us as we unravel the intricacies of insurance fraud, bringing you the insights that matter. Welcome to SIU Spotlight.

Ari Brownstein, Esq. and Matthew Burdalski, Esq. ◆



Understanding Reimbursements for CPT Code 97039

By: Alexander Mendez, Esq. | Florida

CPT code 97039 has been in a state of constant flux in Florida, and recent rulings have created greater change. First, one must understand 97039 and its history. According to the American Medical Association (AMA), CPT code 97039 is a medical procedure that falls under "Constant Attendance Physical Medicine and Rehabilitation Modalities." This requires direct, one-on-one contact with the patient by the provider, meaning the provider performs the treatment directly and said treatment should not be performed contemporaneously with another procedure. Only the actual time of the skilled therapist's direct contact with the patient is covered. CPT code 97039 is used when a therapy modality does not have a specific code that is reimbursable under Medicare.

Typically, this code was reimbursed at $15.00 under the Florida Workers' Compensation Fee Schedule. However, things changed after *United Automobile Insurance Company v. Lauderhill Medical Center LLC a/a/o Robert White*, 350 So.3d 754 (Fla. 4th DCA 2022), where the Fourth District Court of Appeals (DCA) held that the actual treatment and the services control, not the billed CPT code. If a CPT code is no longer recognized but reimbursable, then the insurer cannot simply default to the Workers' Compensation Fee Schedule. If the CPT code is no longer valid but the service remains reimbursable under Medicare, then the insurance carrier must make a reasonable analysis determination. That is, if the carrier determines the charge to be reasonable, it should reimburse 80% of the usual and customary charges.

When a carrier sees CPT code 97039 on a CMS 1500 form, it must look beyond the code and review the medical records in order to make a determination of what modality or treatment service was truly rendered. The carrier must then analyze whether "this service [is] reimbursable under Medicare." *Id*. This begs the question, "When can a carrier default to the Florida Workers' Compensation Fee Schedule rate of $15.00?" The court seemed to allow reimbursement under the Workers' Compensation Fee Schedule when the service is *not reimbursable* under Medicare. *See Id*. An example of this would be if a provider submits a bill using CPT 97039, and the modality of treatment provided was "dry hydrotherapy." Dry hydrotherapy is *not* a reimbursable code under the Medicare Coding and Policy guidelines. Specifically, Medicare has made a decision that dry hydrotherapy is an investigatory procedure

and considered not reasonable or medically necessary. *See* CMS.gov Memorandum L35036 re: Therapy and Rehabilitation Services (PT, OT). As such, the proper reimbursement rate would be under the workers' compensation guidelines. *See, United Automobile Insurance Company v. Lauderhill Medical Center LLC a/a/o Robert White*, (Fla. 4th DCA 2022).

Another example would be if the provider submits CPT code 97039 for reimbursement, and the treatment render was for whirlpool therapy. Whirlpool therapy under Medicare Coding and Policy guidelines is billable under CPT code 97022. *See* CMS.gove Memorandum A53058 re: Billing and Coding: Home Health Physical Therapy. CPT code 97022 is still an active CPT code under Medicare and still shows reimbursement amounts under the Centers for Medicare and Medicaid Services. However, Medicare's coding policy does require separate documentation reflecting medical necessity for the procedure. *See Id*. If the medical records are unquestionable and explicit that treatment was rendered for whirlpool therapy and the CPT code billed was 97039, a carrier may "crosswalk" CPT code 97039 to 97022 and reimburse under CPT code 97022.

While the Fourth District Court of Appeals in *Lauderhill Medical Center LLC* gave further clarification on CPT code reimbursement methodology, it is key for carriers to remain vigilant in the constantly changing landscape of Florida PIP litigation. If a carrier wishes to avoid litigation, then it seems the most practical reimbursement would be 80% of the billed amount for CPT code 97039.

Alex is a member of the firm's Fraud and Special Investigation Unit (SIU) Practice Group and is located in Fort Lauderdale, Florida. In this arena, he works in tandem with insurance carriers evaluating cases and taking Examinations Under Oath on SIU-related issues, resolving PIP disputes within the state of Florida.

Class Action Out of Minnesota with Potential Impacts on Litigating and Negotiating Major Case

Matthew J. Burdalski, Esq. | New Jersey

A class action suit is brewing in Minnesota with the potential for major implications in the way major case investigations are litigated and negotiated. In *Taqueria El Primo LLC et al. v. Illinois Farmers Ins. Co. et al.,* Civil No. 19-3071, the United States District Court for the District of Minnesota has certified a class action against Illinois Farms Insurance. The plaintiffs allege that so called "no-bill" or billing moratorium agreements between Farmers and certain medical providers are in violation of the Minnesota Deceptive Trade Practices Act, the Minnesota Consumer Fraud Act and the terms of the policy of insurance. The plaintiffs further allege that the billing limitations impacted have the potential to effect the ability of insureds to use PIP benefits under their policies to seek treatment with health care providers of their choice.

Following SIU investigations revealing what Farmers believed to be fraudulent billing practices on the part of certain health care providers treating its insureds, Farmers entered into confidential settlement agreements with those health care providers in the state of Minnesota in which the providers agreed, in exchange for a settlement of Farmers' claims, to not bill Farmers for treatment to its insureds. There were various such agreements with differing terms and conditions. The agreements, again with some exceptions, were also confidential per the terms and the settlements. Often, the confidentiality of the agreements was requested by the health care providers.

The plaintiffs filed suit, alleging those non-disclosed agreements constituted unfair and illegal practices on the part of Farmers, resulting in the class members not receiving the value guaranteed by the policies of insurance purchased as they would not be able to use their No Fault Benefits with any health care provider covered by such agreements. The plaintiffs are seeking monetary damages and injunctive relief voiding any such existing agreements.

Farmers contends that the agreements were at all times legally permissible and has denied any and all violations of Minnesota law. Farmers argued that there was no proof at all from any class representative that medical treatment was sought and denied as a result of any no-bill Agreement and that such agreements touched so small a percentage of available providers in the state that there was no likelihood of any actual damage to any class member.

The court ultimately approved the class action for monetary and injunctive relief on the Minnesota Consumer Fraud Act (MCFA) claim only. Regarding the breach of contract claim, the court agreed there had been no actual breach applicable to the class since there would need to be individualized evidence of a claim denied based on the at-issue agreements for the members of the class. The Uniform Deceptive Trade Practices Act claim was similarly dismissed as there could be no theory of damages applicable to the class as a whole.

Regarding the MCFA claim, the court allowed it to go forward. The MCFA prohibits the "act, use or employment by any person of any fraud, false pretense, false promise, misrepresentation, misleading statement or deceptive practice, with the intent that others rely thereon in connection with the sale of any merchandise, whether or not any person has in fact been misled, deceived, or damaged thereby…" Minn. Stat. § 325F.69, subd. 1. In short, the court found that the MCFA claim could proceed since it is not necessary to show any individual consumer's reliance on the purported wrongful conduct. All that is required is a causal nexus between the conduct and the damages the plaintiffs established through direct or circumstantial evidence. The court found the case raises several common questions applicable to all class members:

- Whether the billing limitations violate the No-Fault Act;
- Whether the billing limitations violated the policies;
- Whether Farmers would have been able to sell the policies with the limitations at all;
- Whether Farmers would have been able to sell the policies only if it disclosed the limitations; and
- Whether under Minnesota law it is inherently material and harmful to all purchasers as a matter of law, irrespective of individual consumer differences, if a company was only able to sell a product by fraudulently omitting a fact that, if disclosed, the company would have been barred from selling.

The court likewise found that resolution of those questions posed several common questions of law which predominated over any differences between the class members. Finally, the court found that, if the plaintiffs' theories were correct, damages could be measured on a class-wide basis, thus meeting the final elements necessary for class certification.

The court did not engage in any discussion of the merits of the claims, but the very fact that the classes were certified and the legality of the no-bill agreements will now be litigated is a substantial development for the insurance community and SIU specifically. The failure to disclose the no-bill agreements to current and prospective insureds seems to have been the sticking point with the court. However, as previously noted, that confidentiality was bargained for by, in most cases, the health providers and their attorneys.

No-bill agreements have been an important tool utilized by insurers and SIU to effectively prevent further fraudulent billing by bad actor health care providers taking advantage of No-Fault benefits across the country. Such agreements arguably work to the benefit of insureds by preventing improper treatment and billing, and they keep fraudulent actors at bay, resulting in reduced premiums. However, this current legal landscape puts those agreements directly at risk and should be followed closely.

Matt is a shareholder in the firm's Fraud/Special Investigation Practice Group where he focuses primarily on large loss fraud and medical provider fraud. His practice in the area of fraud investigation involves the assessment and evaluation of both medical provider fraud and fraudulent claims on the part of his clients' insureds. ◆

The Wild West on the East Coast: How the Fix Known as "No-Fault" Turned New York Into the O.K. Corral

By Matthew Gray, Esq. | New York

Howdy! Did y'all come to hear about the virtues and triumphs of New York State No-Fault? Well, sit on down and warm yourself by the fire, while I tell you the story of how a new little law gave way to greed, corruption and the white knights, known as Defense Counsel!

Introduced in 1974, New York State's No-Fault insurance system, controlled under Regulation 68 or 11 NYCRR Part 65, otherwise known as "the Regs," quickly became the foundation of how auto accidents were dealt with and how compensation was disturbed. The Regs were meant to provide quick and efficient coverage for medical expenses, lost wages and other such claims for reimbursement post-auto accident: all without the need for drawn-out legal battles. However, over the decades since its inception, and with the many amendments to the Regs, multiple dusty trails for deceptive practices have been uncovered. Originally what was intended as a streamlined method to process claims and have parties taken care of has become a standoff of the highest order.

No-Fault law was created with certain tenets in mind which aim for the swift processing of claims. Two such tenets are that (1) claims be processed with haste and (2) the parties involved work together, amicably. While the basic and establishing principle of No-Fault law was always to ensure that auto accident victims received timely compensation for medical bills, etc., those who have taken on the practice seem to break into one of two groups: the lawmen who try to protect the public (Defense Counsel) and the outlaws trying to disturb the peace (Plaintiff's Counsel).

While it may be true that those seeking medical treatment are oft seen and treated without haste or worry, the trouble starts when the bad eggs from the medical field roll into town, enlisting Plaintiff's Counsel firms to perpetrate their nefarious plans. For every provider properly billing and treating patients, you will find a bad actor hiding in the herd, causing chaos and frustration throughout. One may ask themselves, "But, how can just a few bad actors affect an industry?" In the simplest of terms, any Defense Counsel worth their boot leather would say, "The premiums." You see, it is our job to protect our clients' interests. When our job is done well, we are able, as Defense Counsel, as lawmen, to keep the bad providers out of our town. By analyzing the cases we are assigned, and by recognizing the tell-tale signs of fraud and

overbilling, we protect our clients from paying out claims they would not otherwise have to; thus, saving them in exposure. This is repaid to the good citizens of our settlement, to those who enlist the protection of the insurance carriers, by allowing them to have affordable premiums and, in turn, allows them to feel protected by the coverages they pay for.

While No-Fault may have been started with good intentions, it has taken a handful of bad eggs, acting with greed in mind, to attempt to exploit the entire system. For as good as Defense Counsel may be, those who seek to defraud our clients are just as skillful. Our adversaries know how, and when, to file suit against the insurance carriers. They know in what venue and in what order to file their suits. They have adapted to the amendments in the Regs, learned each carrier's style of doing business, and they know how, and when, to best overload each carrier. They know that they can file a case on the last day before the statute of limitations (six years from when the claim accrues) and still have many years before any court will take up the case. These methods cost the carriers hundreds of millions of dollars annually, resulting in higher premiums and a lower quality of medical care.

On one side, the bad-acting providers, seeking to force cases to trial, overburdening the carriers and courts with superfluous motion practice or, even as insidious, failing to respond to Defense Counsel's requests to resolve the matter in a timely fashion.

The other side, the Defense Counsel, tired, ever-fighting, working to make the town safe for those just seeking a better quality of auto insurance coverage.

Effectively, we are locked in a daily standoff. However, it does feel like a victory whenever we can resolve a case. We close a case and get a little closer to what No-Fault is really about.

Matthew is a member of the Fraud/Special Investigation Practice Group, where he defends against intentional/staged losses, as well as medical provider fraud. He has experience conducting Examinations Under Oath/Depositions.◆

Is the Operator of a Low-Speed Electric Scooter a "Pedestrian" Under N.J.S.A. 39:6a-2(H) and Entitled to PIP Benefits?

By Gary Lesser, Esq. | New Jersey

By way of background, on November 22, 2021, David Goyco was operating a Segway low-speed electric scooter ("LSES"), which has a maximum speed of 15.5 miles per hour, when he was struck by an automobile. As a result of the collision, Goyco sustained bodily injuries and incurred expenses associated with his medical treatment.

At the time of the accident, Goyco was insured under a policy of automobile insurance issued by Progressive Insurance Company. Goyco filed a claim for PIP benefits with Progressive Insurance Company. Progressive denied the claim stating that the LSES that Goyco was operating at the time of the accident did not meet the definition of a qualifying automobile pursuant to N.J.A.C. 39:6A-2(a) of the New Jersey Auto Insurance Law.

Progressive further denied Goyco's claim for PIP benefits arguing that the LSES that was being operated at the time of the accident does not qualify him for meeting the definition of a pedestrian. Pedestrian is defined as "[a] ny person who is not occupying, entering into, or alighting from a vehicle propelled by other that muscular power and designed primarily for use on highways, rails and tracks." N.J.A.C. 39:6A-2(h).

In New Jersey, motorized scooters are generally categorized as the same as motorcycles. As such, they are not subject to the statutory PIP benefits. *See, Gerber v. Allstate Ins. Co*., 161 N.J.Super. 543, 391 A.2d 1285 (Law Div.), holding that a motor scooter is a motorcycle. *See also, Muto v. Kemper Reinsurance Co*., 189 N.J.Super. 417 (App. Div. 1983), holding that motorcycle does not fall within the definition of an automobile.

However, a person not using a motorized or self propelled bicycle fits the definition of a "pedestrian" for the purposes of pedestrian PIP. *See, Harbold v. Olin,* 287 N.J.Super, 35 (App. Div. 1996), where it was found that, "[a] person riding a bicycle is considered a pedestrian for purposes of [New Jersey] automobile insurance laws. *See also, Nuang by Nuang v. Pennsylvania Nat. Mut. Cas. Ins. Co.,* 224 N.J.Super. 753, 758, 541 A.2d 306, 308 (App. Div. 1988), holding that mopeds are always to be considered vehicles propelled by other than muscular power.

On May 13, 2019, Governor Murphy issued a press release explaining that Bill S731 (N.J.S.A.

39:4-14.16(g) was passed so that "motorized scooters and e-bikes capable of traveling 20 miles per hour or slower [could] be regulated much the same as ordinary bicycles, allowing their operation on streets, highways, and bicycle paths in this State." It was further explained that such bicycles and scooters will not require registration, insurance, or a driver's license. Moreover, it was explained that "[t]he bill further provides that all statutes, rules and regulations that apply to ordinary bicycles will apply to low-speed electric bicycles and motorized scooters."

Goyco filed a lawsuit in Superior Court challenging Progressive's denial of his claim. He argued that New Jersey law does recognize bicyclists as pedestrians for purpose of PIP coverage, and by extension, a LSES should be considered the equivalent of a bicycle pursuant to N.J.S.A. 39:4-14.16(g).

The trial court dismissed Goyco's complaint saying that, plaintiff was operating a scooter powered by motor at the time of the incident. As the scooter is clearly not considered a motor vehicle, neither in statute nor in the insurance policy, it must be determined if plaintiff would be considered a pedestrian. The trial court further found the plaintiff's reliance on N.J.S.A. 39:4-14.16(g) is misplaced as the Statute is not a part of the No-Fault statute and is not controlling over the New Jersey Auto Insurance Law.

Moreover, the trial court found that the definition of pedestrian in N.J.S.A 39:6A-4 "clearly has no application to an LSES either...[t]he LSES was not muscular powered thus does not meet the requirements of the statute."

Thereafter, Goyco filed an Appeal to the Appellate Division.

On July 5, 2023, the Appellate Division held that a plaintiff injured while operating a low-speed electronic scooter did not qualify for Personal Injury Protection ("PIP") benefits. *See, Goyco v. Progressive Insurance Company*, 302 A.3d 1176 (2023).

On Appeal, the panel noted that N.J.S.A. 39:1-1 expressly defines a LSES as having "an electric motor that is capable of propelling the device with or without propulsion." "As Judge Hudak found, the definition of pedestrian under N.J.S.A. 30A:6-4 is incompatible with the definition of a LSES and, therefore, N.J.S.A. 39:4-14.16(g), by its terms, has no application here.

The panel was also not persuaded that an LSES operator can be equated to a bicyclist, noting that the statute's exception defeats this argument. They found that "[a]ll statutes . . . rules and regulations applicable to bicycles. . . shall apply to a LSES except those provisions which by their very nature may have no application to . . . a LSES."

As such, the Appellate panel affirmed the lower courts dismissal of the complaint.

On October 6, 2023, The New Jersey Supreme Court granted Goyco's petition for certification and has agreed to review this ruling and establish whether or not the operator of a low-speed electric scooter is a 'pedestrian' under N.J.S.A. 39:6A-2(h), and therefore entitled to PIP benefits.

On May 14, 2024, the Supreme Court of New Jersey affirmed the Appellate Division decision.

The Supreme Court unanimously rejected Mr. Goyco's reliance on N.J.S.A. 39:4-14.16(g). The Court held that by its very definition the electronic scooter is a vehicle propelled by other than muscular power (battery-power) and designed primarily for use on highway. The Court affirmed that, "by their very nature," a low-speed electronic scooter does not qualify for PIP benefits.

Therefore, Mr. Goyco was not a "pedestrian" for PIP benefits afforded to bicyclists as per the definition in N.J.S.A. 39:6A-2(h).

The Supreme Court declined to expand the definition of pedestrian without more explicit language in the statute. Additionally, the Supreme Court also found that the scooter was "designed primarily for use on highways, rails and tracks," even though the device used by Mr. Goyco on November 22, 2021, could not go faster than 15.5 miles per hour. The Court noted that "highway" is defined broadly as any main route, free to the public, such as a public road.

Following the Supreme Court's ruling, if a motor vehicle accident involves a motorized scooter being operated in New Jersey, the occupant of that scooter is not a pedestrian and will not be entitled to PIP medical expense benefits.

Gary has extensive experience in disputes involving Personal Injury Protection claims and bodily injury claims. He also handles matters as a member of the Fraud/Special Investigation Practice Group. Gary primarily deals with evaluating both medical provider fraud and intentional/staged losses. In this arena, he has significant experience conducting Examinations Under Oath as it relates to both specific claims and broader SIU investigations. ◆

Exciting Announcement: Jonathan Magpantay Is Now Barred in Michigan!

We are thrilled to announce that Jonathan has recently been barred in Michigan! As a valued member of our firm's Fraud and Special Investigation Unit (SIU) Practice Group, Jonathan brings significant experience in large loss and medical provider fraud, affirmative litigation recovery actions and RICO cases to this new jurisdiction. His national practice also includes handling insurance coverage disputes, bad faith litigation and general defense litigation for insurance carriers across multiple states.

Jonathan's career is marked by his innovative approaches to solving complex problems in the insurance industry. He advises clients on initiatives to modernize and administrate automobile first-party medical claims and has conducted Examinations Under Oath in various insurance matters nationwide. His extensive experience in New Jersey Personal Injury Protection (PIP) litigation has made him a regular presence in courts and administrative bodies.

Before joining Marshall Dennehey, Jonathan served as claim litigation counsel for a national insurance carrier, managing PIP disputes, coverage issues, and automobile and fire claim litigation. He led review teams to assess and improve ethics and best practices within national staff counsel operations.

In addition to his new admission in Michigan, Jonathan is admitted to practice in New Jersey, the District of Columbia and the United States Supreme Court. He is actively involved in several legal associations and committees, including the Asian Pacific American Lawyers Association of New Jersey (APALA-NJ), the National Filipino American Lawyers Association (NFALA) and the Diversity, Inclusion & Community Engagement Committee (DI&CE) of the New Jersey Superior Court, Camden Vicinage.

Jonathan also holds Chartered Property and Casualty Underwriter (CPCU), Associate in Insurance Services (AIS), and Associate in Personal Insurance (API) designations from the American Institute of Chartered Property and Casualty Underwriters.

We congratulate Jonathan on this significant achievement and look forward to his continued success and contributions to our firm and clients in Michigan!

UPCOMING EVENTS:

IASIU August 25-28, Nashville, TN
NJSIA October 21-23, Atlantic City, NJ
December 9-10, 2024 Coalition Against Insurance Fraud Annual meeting

Interested in training your claims professionals? Contact **Ariel Brownstein** at ACBrownstein@mdwcg.com or (856) 414-6075 for training opportunities in 2024 and 2025.

Changes in Insurance Fraud Law Takes Case for a Ride

By Jonathan C. Magpantay, Esq., CPCU | New Jersey

The unpublished case of *Hiram Settler v. Auto-Owners Ins. Co*., 2023 WL 5157685, illustrates the impact of evolving case law and changes in insurance fraud litigation in the state of Michigan. In *Settler*, the plaintiff was injured in a motor vehicle accident that occurred in 2017. He sought no-fault benefits from his insurance carrier and submitted an application for benefits, which contained material misrepresentations regarding the nature of his injuries. Moreover, the plaintiff continued to make material misrepresentations through statements and related documents during the claims process. Three months after the plaintiff submitted his application for benefits, formal litigation against the defendant insurance carrier for no-fault benefits commenced.

At the trial level, the insurance carrier sought summary judgment, asserting that under the fraud provision of the insurance policy, it was entitled to deny coverage because the plaintiff made numerous fraudulent statements with respect to the accident, his prior medical history and his need for attendant-care services. The trial court concluded that the fraud provision of the insurance policy was enforceable against the plaintiff, granting the defendant's motion based on the plaintiff's submission of attendant-care forms, which the trial court concluded contained fraudulent statements about services needed or performed.

The plaintiff appealed, arguing the defendant was not entitled to deny all coverage on the basis of the purported fraud in the attendant-care forms. On appeal, the appellate court concluded that the trial court erred when it granted the defendant's motion for summary judgment as to all of the plaintiff's claims because, under *Meemic Ins. Co. v. Fortson*, 506 Mich. 287; 954 N.W.2d 115 (2020), an insurer may only void the policy when the fraud is committed when procuring the policy. In addition, the appellate court noted that under *Haydaw v. Farm Bureau Ins. Co.,* 332 Mich.App. 719, 957 N.W.2d 858 (2020), a defendant could not rely on allegedly fraudulent statements made by the plaintiff in his attendant-care forms because the "statements" were made after the litigation commenced. The appellate court vacated the trial court's order for summary judgement and remanded for the trial court to render a decision consistent with the framework set forth in *Meemic* and *Haydaw*, which were decided after the trial court rendered its decision.

On remand, the trial court granted the defendant ▸

insurance carrier's renewed motion for summary judgment, which the plaintiff appealed. The plaintiff argued that the trial court erred since the application for benefits was post-procurement and any such fraud cannot form a basis to dismiss the entire claim. The appellate court rejected the plaintiff's argument and found the trial court's decision consistent with *Meemic* and *Haydaw*. The appellate court found that, regardless of whether the plaintiff's application for benefits is considered pre- or post-procurement, there was no dispute that the application was submitted to the defendant before litigation commenced. Thus, even if the application was considered post-procurement, the defendant was still entitled to deny coverage on the basis of the purported fraud. The defendant was not entitled to void the policy as a result of the plaintiff's application for benefits, but it was entitled to deny the claims that flowed from it. Therefore, the trial court did not err when it concluded that the plaintiff's application for benefits could serve as a basis for the defendant's fraud defense and denial of coverage.

As seen in Settler, the framework of *Meemic* and *Haydaw* created nuance, and potential limiting factors, as to when a fraud defenses can be asserted. Now more than ever, claim analysis and strategic discovery are critical. The added complexity requires insurance carriers to diligently investigate and ascertain the basis of potential fraud defenses in order to navigate a legal landscape that is constantly evolving.

Jonathan is a member of the firm's Fraud and Special Investigation Unit (SIU) Practice Group. His practice is dedicated to large loss and medical provider fraud and he has litigated and filed affirmative litigation recovery actions multiple states and jurisdictions. He is admitted to practice in Michigan, New Jersey and District of Columbia.

Do Not Forget the Anesthesia! Investigating the Use of Anesthesia During Common Interventional Pain Management Procedures

By Ari Brownstein, Esq. | New Jersey

Interventional pain management treatment frequently begins with a series of epidural and facet injections that are are performed in surgical centers and under anesthesia. Billing received is from three parties: the injecting physician, the anesthesiologist and the surgical center. Investigations and peer reviews have long focused on the first leg of the troika—the in jecting physician—whether the patient had the requisite subjective complaints and response to treatment as being reported by the patient's providers. Anesthesia has long been considered part and parcel of the injections; if the injection was considered medically necessary, anesthesia was medically necessary. However, this commonly held belief must be changed, and the use of anesthesia for these procedures should go through the same investigational rigor by carriers' SIU departments and independent peer review physicians.

CMS's position is that the use of moderate or deep sedation, general anesthesia, and monitored anesthesia care is "usually or rarely indicated" for epidural and facet injections and that, in exceptional use and unique cases," there must be supporting documentation to establish the need for sedation for the specific patient. See, LCD – *Epidural Steroid Injections for Pain Management (L39054) and LCD – Facet Joint Interventions for Pain Management (L38803).*

From an investigational standpoint, carriers should be reviewing the injecting physician's records to determine if there is any basis provided for the need for anesthesia. Many providers simply denote that anesthesia would be utilized, without providing any patient-specific reason. A second scenario is where providers note that anesthesia is indicated because patients need to stay completely still. However, there is no evidence-based medical support for this position, and the American Society of Anesthesiologists (ASA) does not indicate that epidural and facet injections are procedures that require a patient to remain motionless for a prolonged period of time. *See, ASA's Statement on Anesthetic Care During Interventional Pain Procedures for Adults.*

The the third and growing scenario that providers present are patients who have a needle phobia or anxiety. A review of these providers' pre-certification requests reveals the same cookie-cutter language as to the patients' fear of needles and anxiety over the procedures. This provides an opportunity for SIU. First, is this statement supported by the

patient's treatment history since the subject loss? Did the patient previously receive acupuncture, EMG/NCV testing or an in-office injection from another specialty? Moreover, recorded statements and Examinations Under Oaths need to be utilized to confirm this basis. Are we asking our insureds/claimants whether they have a needle phobia? Did their physicians ever discuss with them anesthesia for these procedures? Was the need for anesthesia presented as office policy and a requirement to receive these injections or was anesthesia based on patient-specific needs? Accordingly, a simple review of the patient's medical records and asking the right questions should be able to determine whether there are any misrepresentations being presented for the use of anesthesia.

Finally, our industry needs to expect more from our independent physicians when reviewing requests for these procedures. The epidural or facet injection is only one piece of the pie that needs to be reviewed and discussed during peer reviews/independent medical examinations. Our physicians need to opine as to the need for anesthesia and whether the precertification request provides any unique patient-specific reasons to support anesthesia. The more in-depth peer reviews that discuss the need for every aspect of the injections—the need for the injection, the need for anesthesia and the need for use of a surgical center—will provide a stronger and a more diverse medical necessity defense during litigation.

Ari is a shareholder in the Casualty Department, focusing his practice on insurance fraud and Special Investigation Unit (SIU) litigation with particular emphasis on large loss fraud and medical provider fraud. His practice in the area of fraud investigation consists of assessing and analyzing fraud by both medical providers and falsified claims brought by his client's insureds. ◆

Welcome to Marshall Dennehey

We are thrilled to announce the newest additions to our esteemed legal team—the following talented PIP and SIU attorneys who bring a wealth of knowledge and dedication to our firm.

Gary T. Lesser, Esq.
"Handling matters from both sides, as well as deciding thousands of cases as an arbitrator, gives me a unique perspective that allows me to approach each matter with a balanced understanding and comprehensive view, affording me the ability to develop effective strategies that ensures that our clients' interests are protected."

Gary joined our Roseland, New Jersey, office as special counsel, handling Personal Injury Protection (PIP) and fraud/special investigation matters. He earned his *juris doctor* from the Cardozo School of Law in 1993 and a Bachelor of Arts in Political Science from Binghamton University in 1990.

Maura R. Ryan, Esq.
"While I am new to Marshall Dennehey, I have learned a lot through the attorneys mentoring me. I am passionate about strategizing how to best represent our clients, case-by-case."

Maura is primarily involved in both the New Jersey Personal Injury Protection practice and in the New York exaggerated injury and fraud cases. She is originally from Pennsylvania, where she attended the Penn State Smeal College of Business, graduating with a Bachelor of Science degree in Supply Chain Management. Maura then attended law school at Drexel's Thomas R. Kline School of Law, graduating in 2022.

Aneshia Chintamani, Esq.
"Navigating the constantly evolving terrain of PIP litigation keeps me on my toes, driving my commitment to effectively represent Marshall Dennehey's clients."

Aneshia is no stranger to New York PIP litigation. Prior to joining Marshall Dennehey, she served as in-house counsel for five years at a national insurance company, handling PIP litigation in civil court, district court and arbitration forums throughout the state of New York. She graduated from Brooklyn Law School and earned her Bachelor of Arts in Political Science and Minor in Philosophy and Criminology from John Jay College of Criminal Justice.

Fraud / Special Investigation

Insurance fraud is, understandably, no longer tolerated or in any way compromised by insurance companies and self-insureds. We work very closely with our clients in furtherance of that philosophy through relentless investigation, aggressive defense, and prosecution in response to false and inflated insurance claims.

The attorneys in this practice group supplement their litigation experience with up-to-date knowledge of the current trends in insurance fraud detection and prosecution areas by regularly attending and participating in seminars given by such educational agencies as the National Insurance Crime Bureau, International Association of Special Investigation Units and Certified Fraud Examiners. In addition, they also attend numerous local conferences and association meetings throughout Pennsylvania, New Jersey, Delaware, Ohio, Florida and New York.

As part of our fraud practice, we regularly handle PIP matters for our clients. Our team of attorneys are familiar with all local PIP regulations and have significant experience handling all facets of PIP litigation, including IME cut-offs and opinions on absences of injury as well as EUO investigation of prior medical history. Other PIP practice areas include UCR litigation, medical necessity defense, and provider and claimant regulatory compliance. We routinely partner with our clients to help create PIP protocol and manage the defense of PIP litigation. Our attorneys are knowledgeable and focused on an array of contemporary medical procedures and codes that often flood the PIP industry.

The increase in auto glass claims has changed the industry's perception. Our attorneys are focused on glass litigation, in both the defensive and affirmative ligation recovery model, against fraudulent actors. Our team has national experience in defending and civilly prosecuting these claims.

Aggressive Fraud Defense

As a part of an overall aggressive fraud defense, the Insurance Fraud & Special Investigations Practice Group members believe that the "best defense is a good offense." Our trial attorneys are quite experienced in the investigation, defense and affirmative prosecution of fraudulent claims. The scope of their practice is not only focused on the individual claimant, but also on organized groups or "rings." We routinely file suits and collect judgments against perpetrators of insurance fraud, including both insureds and medical providers.

We have considerable experience with cases involving:

- Medical Provider Fraud
- Claimant Fraud
- Arson
- Vehicle Theft
- Suspicious Jewelry Claims
- Claim Inflation
- Body Shop Fraud
- Application Fraud
- Auto Glass Claims

We maintain a centralized "fraud library" of fraud scams, investigations and perpetrators. Dissemination of this information to the group members, as well as a constant dialogue between our attorneys, allows them to immediately incorporate current law and recent events in the fraud industry into defense strategies. We, in turn, enable our clients to incorporate this knowledge and experience into investigations by providing them with updates concerning recent developments in the industry. Our clients greatly appreciate the fact that we collaborate with them in the course of investigations in order to coordinate efforts and ensure that the goals of fighting fraud are met.

We would welcome the opportunity to work with you in vigorously defending against insurance fraud claims. Members of our practice group are also available to give presentations at your location or in one of our offices.